Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage For: City of Burlington **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/vfp_cert or by calling (800) 255-4550. To access or request a copy of the Uniform Glossary, please visit www.bcbsvt.com/glossary or call (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	**Preferred providers** $200 Individual / $400 Two-Person/Family per plan year **Non-Preferred providers** $500 Individual / $1,000 Two-Person/Family per plan year The plan pays benefits when an individual or the family meets the deductible. The deductible for preferred and non-preferred providers is separate. Co-insurance and co-payments do not count towards the deductible. Does not apply to preferred colorectal screenings, preventive mammography screenings, and office visits with preferred providers. Does not apply to participating preventive services or prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the "Common Medical Event" chart, that appears later in this document, for how much you pay for covered services after you meet the deductible. Your plan year: **January 1, 2013** through **December 31, 2013.** All accumulators, such as **deductibles**, **out-of-pocket limits** and benefit limits apply to your plan year for all medical and prescription drug benefits.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services, but see the "Common Medical Event" chart, that appears later in this document, for other costs for services this plan covers.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vfp_cert. If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy.

Important Questions	Answers	Why this matters:
Is there an **out-of-pocket limit** on my expenses?	**Preferred providers** Yes. $600 Individual / $1,200 Two-Person/Family per plan year **Non-Preferred providers** Yes. $1,500 Individual / $2,000 Two-Person/Family per plan year The out-of-pocket limit for preferred and non-preferred providers is separate. $1,250 Individual/ $2,500 Two-Person/Family prescription drug out-of-pocket limit per plan year	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges and health care this plan doesn't cover. Co-payments do not apply to your medical or prescription drug out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The "Common Medical Event" chart, that appears later in this document, describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of preferred providers, see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the "Common Medical Event" chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan. Some services require prior approval.

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section of this document. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$10 co-payment per visit	Deductible, then 30% co-insurance	See also, "If you have a test" for diagnostic tests or imaging.
	Specialist visit	$10 co-payment per visit	Deductible, then 30% co-insurance	Certain **provider** specialties must be preferred or there is no benefit. See also, "If you have a test" for diagnostic tests or imaging. Some services require prior approval.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Other practitioner office visit	Chiropractor: $10 co-payment per visit Nutritional counseling: $10 co-payment per visit OB/GYN: $10 co-payment per visit	Chiropractor: Not covered Nutritional counseling: Not covered OB/GYN: Deductible, then 30% co-insurance	Requires prior approval after 12 chiropractic visits per plan year. Nutritional counseling benefits covered up to three visits per plan year. Visits for treatment of diabetes do not count toward this visit limit.
	Outpatient physical, speech and occupational therapy	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Covered up to 30 visits combined per plan year.
	Preventive care/Screening/Immunization	No charge	Deductible, then 30% co-insurance	See also, "If you have a test" for diagnostic tests or imaging. Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bcbsvt.com/preventive.
	Preventive care tests	No charge	Deductible, then 30% co-insurance	Only applies to PSA or PAP tests. See also, "If you have a test" for diagnostic tests or imaging.
	Screening mammogram	No charge	No charge	See also, "If you have a test" for diagnostic tests or imaging.
	Colorectal screening	No charge	Deductible, then 30% co-insurance	See also, "If you have a test" for diagnostic tests or imaging.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have a test	Diagnostic test (x-ray, blood work)	Office based: Deductible, then 20% co-insurance Outpatient hospital: Deductible, then 20% co-insurance	Office based: Deductible, then 30% co-insurance Outpatient hospital: Deductible, then 30% co-insurance	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	Retail: $10 co-payment per 30-day supply Home Delivery: -$10 co-payment per 30-day supply -$20 co-payment per 60-day supply -$20 co-payment per 90-day supply	Not covered	Some prescription drugs require prior approval. Prescription drug out-of-pocket limit: $1,250 Individual/ $2,500 Two-Person/Family per plan year. Benefits provided for up to a 90-day supply for most prescription drugs. All generic and brand diabetic prescription drugs are covered at 100%.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Preferred brand drugs	Retail: $15 co-payment per 30-day supply Home Delivery: -$15 co-payment per 30-day supply -$30 co-payment per 60-day supply -$30 co-payment per 90-day supply	Not covered	Some prescription drugs require prior approval. If a drug is only available as a brand-name drug, the Generic co-payment will apply. Prescription drug out-of-pocket limit: $1,250 Individual/ $2,500 Two-Person/Family per plan year. Benefits provided for up to a 90-day supply for most prescription drugs.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Non-preferred brand drugs	Retail: $15 co-payment per 30-day supply Home Delivery: -$15 co-payment per 30-day supply -$30 co-payment per 60-day supply -$30 co-payment per 90-day supply	Not covered	Some prescription drugs require prior approval. If a drug is only available as a brand-name drug, the Generic co-payment will apply. Prescription drug out-of-pocket limit: $1,250 Individual/ $2,500 Two-Person/Family per plan year. Benefits provided for up to a 90-day supply for most prescription drugs.
	Wellness drugs	Wellness drugs process the same as any other prescription. Please refer to the prescription drug benefits identified above.	Not covered	Some prescription drugs require prior approval. Benefits provided for up to a 90-day supply for most prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Some services require prior approval.
	Physician/surgeon fees	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Some services require prior approval.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need immediate medical attention	Emergency room facility services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an **emergency medical condition**. For emergency care, you may use preferred or non-preferred **providers** and obtain preferred benefits.
	Emergency room physician services	$10 co-payment per visit	$10 co-payment per visit	Your condition must meet the criteria for an **emergency medical condition**. For emergency care, you may use preferred or non-preferred **providers** and obtain preferred benefits.
	Emergency mental health and substance use facility and physician services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an **emergency medical condition**. For emergency care, you may use preferred or non-preferred **providers** and obtain preferred benefits.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need immediate medical attention	Emergency medical transportation	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an **emergency medical condition**. All non-emergency transport requires prior approval. You must get approval within 48 hours after emergency air or water transport.
	Urgent care	$10 co-payment per visit	$10 co-payment per visit	For **urgent care**, you may use preferred or non-preferred **providers** and obtain preferred benefits. Applies to **urgent care** facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Out-of-state inpatient care requires prior approval.
	Physician/surgeon fee	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	None
	Mental/Behavioral health office visits	$10 co-payment per visit	Deductible, then 30% co-insurance	None
	Mental/Behavioral health inpatient services	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder office visits	$10 co-payment per visit	Deductible, then 30% co-insurance	None
	Substance use disorder inpatient services	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Members enrolled in our Better Beginnings program receive extra benefits.
	Delivery and all inpatient services	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Out-of-state inpatient care requires prior approval.
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Private duty nursing and home infusion therapy require prior approval. This plan does not cover home infusion therapy with a non-preferred **provider**.
	Rehabilitation services	Inpatient: Deductible, then 20% co-insurance Cardiac/Pulmonary: Deductible, then 20% co-insurance	Inpatient: Not covered Cardiac/Pulmonary: Not covered	This plan does not cover care in a non-preferred physical rehabilitation facility. Requires prior approval. Cardiac rehabilitation covered up to 36 visits per cardiac event.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Habilitation services	Varies based on type or place of service. Please see the applicable row in this table.	Varies based on type or place of service. Please see the applicable row in this table.	Requires prior approval. For applied behavioral analysis (ABA), see "Mental/ behavioral health office visits". See also, "If you visit a health care **provider's** office or clinic" for outpatient physical, speech and occupational therapy.
	Skilled nursing care (facility)	Deductible, then 20% co-insurance	Not covered	Care in a skilled nursing facility requires prior approval.
	Durable medical equipment (including supplies)	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Some **durable medical equipment** and supplies require prior approval.
	Hospice service	Deductible, then 20% co-insurance	Deductible, then 30% co-insurance	Requires prior approval.
If you or your child needs dental or eye care	Eye exam	Child: $20 co-payment per exam Adult: $20 co-payment per exam	Child and Adult: You must pay up front and get approval from our vision network. We pay up to our allowed price less your $20 co-payment for all approved services.	One routine vision exam per member, per calendar year. This benefit does not cover the evaluation and fitting of contact lenses or other supplemental tests.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Cosmetic surgery (except with prior approval for reconstruction)
- Dental care (child and adult)
- Hearing aids
- Long-term care
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care (requires prior approval after 12 visits)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to $2,000 per plan year)
- Routine eye care (one routine eye exam per child and adult member per calendar year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal, or file a grievance. For questions about your rights, this notice, or assistance, you can contact (800) 255-4550.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 255-4550.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:**
- **Patient pays :***

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	*
Co-pays	*
Coinsurance	*
Limits or exclusions	*
Total	*

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:**
- **Patient pays :***

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	*
Co-pays	*
Coinsurance	*
Limits or exclusions	*
Total	*

*Please refer to your costs in the previous sections of this document.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.